CAMPING GUIDE

FOR THE PLACEMENT

OF HANDICAPPED CHILDREN

IN REGULAR CAMPS

COMMUNITY COUNCIL
OF GREATER NEW YORK

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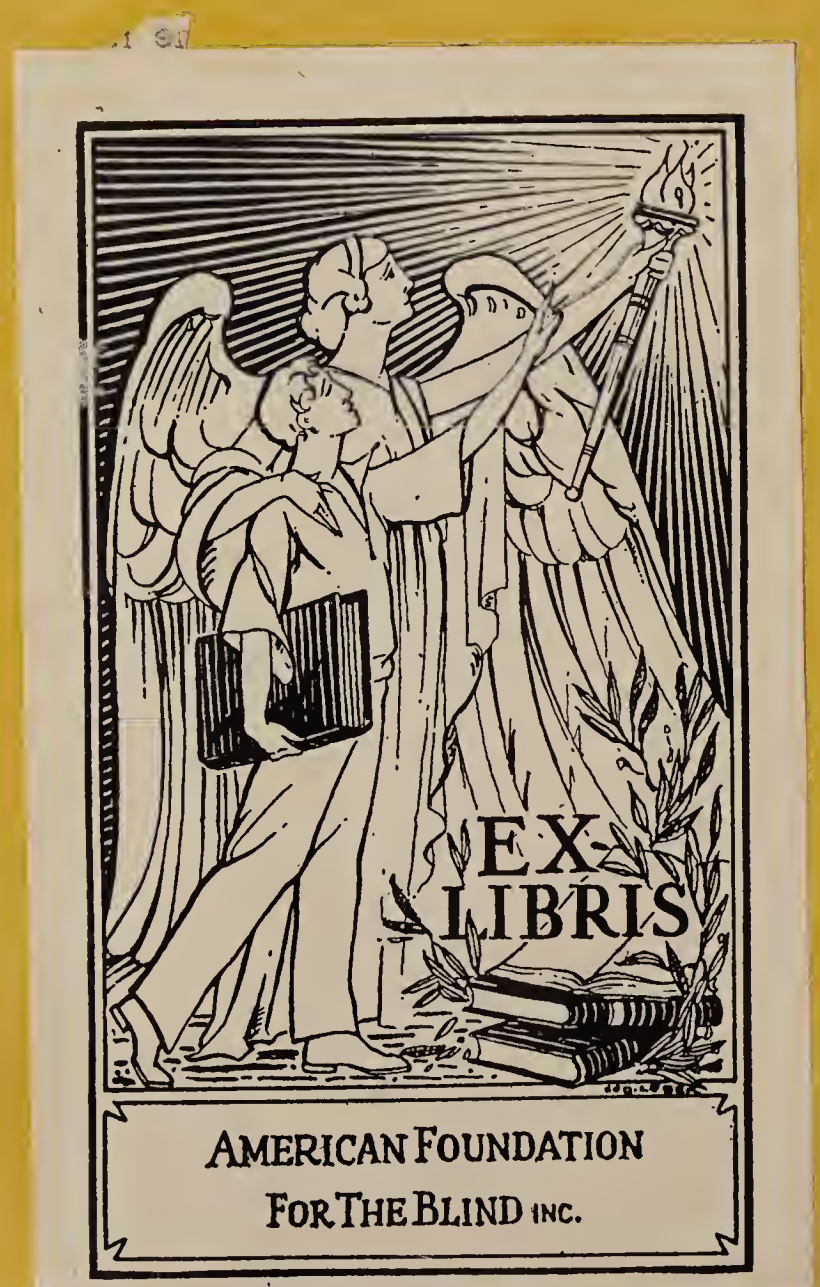

CAMPING GUIDE

For The
Placement of Handicapped Children in Regular Camps

Revision of the

GUIDE FOR THE CAMP PLACEMENT OF HANDICAPPED CHILDREN
by the
Sub-Committee on Camping for tl Handicapped

A cooperative project of the Association for the Aid of Crippled Children and the New York Heart Association with the Community Council

Camping Service
and
Demonstration Project on Group Work with Handicapped

Community Council of Greater New York
44 East 23 Street, New York 10, N.Y.
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FOREWORD

Social, recreational, educational and health agencies no longer look upon camping as an isolated experience in a child's life. Instead, there is an awareness that it can be an important part of the total experiences provided for children. At the same time, there is recognition of the fact that not all children are ready for or can benefit from a camping experience. It is not the purpose of this guide to say that all handicapped children should go to camp, or to camps for physically normal children. Many factors, such as the child's readiness for a group experience, the parents' readiness for separation from their child, need to be considered when deciding that a child should go to camp and the camp most appropriate for him. Not only should the child's emotional readiness for camp be considered but also his physical readiness as reflected in his general health status, in the degree of disability and the child's adjustment to it. If agencies want the children they serve to gain the greatest benefit from camp, a careful job of selecting a particular camp for a particular child is a requisite. This guide outlines the factors that need to be taken into consideration when plans are being made for a child to go to camp and should be helpful to both sending and camping agencies.

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Institute of Physical Medicine and Rehabilitation
New York University-Bellevue Medical Center

PREFACE

History and Purpose

In February of 1945, a group of individuals representing agencies in New York City serving handicapped children met under the auspices of the Children's Welfare Federation to consider the lack of sufficient information about camping facilities for handicapped children. As a result, a Committee on Camping for the Handicapped, sponsored by the Federation with Mrs. Alice FitzGerald, who at that time was executive director of the Association for the Aid of Crippled Children, as chairman, was formed to study the problems of handicapped children in relation to camping. The chief objective of the Committee was to encourage regular camps which had already accepted campers with handicaps to take more of them and to interest other regular camps which had not previously taken children with a physical disability to accept some. The Committee was in agreement that even one child accepted would prove to a given camp that such a child could be included safely in their camp program.

To accomplish this objective a survey was made by members of the Committee which eventually resulted in A Guide for Camp Placement of Handicapped Children. The Committee which prepared the Guide recognized that it would serve as a means of increasing the opportunities for normal camping experiences for the disabled, only if children were carefully selected with consideration for the type and degree of handicap, the physical set-up of the camp and the character of its personnel and program. To achieve this end, the Committee obtained material from experts describing various handicapping conditions, and the most common problems that should be considered by camp administrators and sending agencies in determining the possibility or advisability of including handicapped children in a regular camp.

This first Guide had wide distribution and was in great demand. In 1951 there were sections added on the emotionally disturbed child and the retarded child. Because of advances made in the field of health and welfare over the past decade, it now seems advisable to re-write the Guide and broaden its scope to match the present day camping needs of children with handicapping conditions.

The present revision of the Guide and its distribution is the responsibility of the Camping Service of the Community Council, supervised by Grace Dubois, assistant consultant in Group Work and Recreation, and is a facet of the Council's Demonstration Project on Group Work with Handicapped, supervised by Louise A. Frey. "The goal of the project is to study and facilitate the participation of selected physically handicapped children in group work, recreation and camping programs with non-handicapped."

In considering the diagnostic categories that produce disabilities of varying degrees the present Committee has listed the following areas for special consideration -- asthmatic, cardiac, diabetic, epileptic, hard of hearing (including the deaf), orthopedic (including cerebral palsy and

muscular dystrophy) and visual (including the blind). It is the purpose of the Guide to provide information regarding these particular diagnostic groups that will be helpful to medical, professional and lay personnel on staffs of sending agencies and camping agencies. It is hoped that the Guide will lend authority for decisions that need to be made and, at the same time, alleviate fears that are prevalent today in regard to including handicapped individuals in non-handicapped groups.

In order to obtain the broadest thinking and most current information for the revision of this Guide we consulted with more than one agency and various individuals who are experts in each of the diagnostic categories and in the understanding of children and their needs.

The Committee wishes to express its appreciation to: Dr. Lillian Boker, chief of the Pediatric Allergy Clinic of Vanderbilt Clinic; the Public Health Committee of the New York Heart Association and Dr. Catherine Brownell; T.L. Kingsley of the New York Diabetic Association; Eleanor Ronnei and staff of the New York League for Hard of Hearing; Dr. George Deaver, Mary Stewart, Rita Gotterer and other staff members of the Children's Division of the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center; Maurice Case of the Lighthouse and Elizabeth Maloney of the Industrial Home for the Blind. Their wholehearted cooperation made this revision of the Guide possible.

Florence I. Mosher, Chairman
Sub-Committee on Camping for
Handicapped Children

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GENERAL CONSIDERATIONS FOR THE CAMP DIRECTOR

The Need

Often camp directors will ask why they should integrate selected handicapped children into their regular program. There are several answers to this question. First, there are the obvious mental hygiene and social values inherent in having a camp community representative of the total community with a concomittant climate in which differences are accepted and appreciated. Secondly, if the agency camp is dedicated to service to the community, there can be no question that there are children with disabilities in that community who could make good use of the camping service.

In addition, the more mildly and moderately handicapped youngsters who go to regular camp, the more places will be available to the severely disabled in the specialized camps they require.

From the point of view of the handicapped child himself, the more opportunity he has for positive social experiences with his peers, the better will be his chances for leading the full, rich life to which he is entitled.

Basic Requirements for Integrating the Handicapped

It is not the purpose of this Guide to say that all camps should accept children with disabilities. It is recognized that the terrain, buildings, and programs of some camps would not permit a child with a physical disability to benefit from the experience. Also, some camp staffs are not ready to accept and work with children with visible disabilities. There are adults who find it difficult to establish relationships with children who do have severe physical disabilities and it would not be fair to them nor to the child to encourage the acceptance of these children under such circumstances.

It is particularly important for the supervisory staff of a camp accepting handicapped children to interpret to the counselor staff the meaning and significance of records and inter-agency reports, both social and medical. The relationship between counselor and supervisory administration must be such as to guarantee maximum cooperation in a joint effort to know the child and thus promote healthful adjustment to the camp experience. Assistance in this interpretation may be secured from the sending agency personnel working directly with handicapped children, and should be directed toward helping counselors to become aware of and understand their own feelings toward handicapping conditions.

The personnel of all camps, including those accepting handicapped children, should have a registered, professional nurse on the staff. Camps taking children with certain types of handicaps should have a resident physician. All camps should have a physician on call to meet emergencies. The need of a resident physician will be discussed in the following special sections.

All camps accepting children should meet established standards for housing, sanitation, safety, character and number of counselors and special staff, and adequate diet. Sending agencies have the responsibility of carefully evaluating camps in respect to these accepted standards, before applying for places for a handicapped child.

Camp Program

Important aspects of camp program are its pace, flexibility and variety. These factors indicate how well the camp can make adaptations to the needs of the exceptional child. For example, if there is little flexibility, a handicapped camper will have to be able to keep up with the group at all times. This will require a mildly handicapped child. Where there is greater flexibility and allowance made in program for individual differences and interests, a more involved child could be integrated. A flexible program allows a child to participate in activities suited to his interests and abilities. A group centered program, where the competitive aspect of living is kept to a minimum and where there is close supervision of campers (and counselors) and where there is also time for the child to pursue some special, individual interests, is a good one for most handicapped children.

The Camper

As already indicated, the child must go to the camp which is appropriate for him. He must be physically and emotionally ready to meet the requirements of the camping experience. These physical, social and psychological requirements will be different in different camps. If a child cannot fit into one camp, he may be quite suited for some other camp. However, it should be remembered that many handicapped children will need encouragement and support to help them make their initial adjustment to camp life and to participate in the program.

Grouping

In general, children with handicaps should be grouped with children of their own age, rather than be placed in groups with younger children because the staff may feel that they need closer supervision. While this may have certain advantages, it is more than offset by the injury to the child's self-esteem because he is grouped with younger children and is singled out for special and different treatment. However, there are exceptions and the information received

from the referring agency may indicate this need; e.g. a child with a congenital heart condition may be retarded in all areas of his growth and development, hence would be happier placed with the younger children. Children with disabilities should not be segregated as a group when in a regular camp, unless they are severely disabled and require a special program. It would be very rare, however, that such a separation would be necessary.

The Terrain

The physical terrain of the camp is also important to consider. It can be determined when the child is being interviewed by the camp intake worker whether he will be able to manage camp facilities by asking him and his parent some questions like these (adapting them to whether the child has leg or arm disability):

1. Can you climb steps? How many? Do you need a hand-rail?

2. What happens when you are on rocky ground? Wet ground? In the woods? Climbing a hill? Do you go slower? Does it help if someone holds your arm?

3. Can you run? How fast? When do you fall down?

4. Do you need any help with your braces? What happens when you don't wear them? (This will help you to know if the child will be able to go to the swimming area without braces or if he will remove them at the waterfront).

5. Can you sit on the ground?

6. What help do you need with dressing? Eating?

The interviewer can make a judgment about a child's physical ability by asking him to move around the room at different speeds and by observing him as he comes into the interview. A good idea would be to meet the parent and child as they enter the building for the interview and accompany them to the office. This would provide an excellent opportunity to observe the child's movements.

Of course, most of the necessary information about the child's physical limitations will come from his medical report, but it would be well to observe as much as possible of the child's acceptance of his handicap and his freedom to discuss it.

Medical Information

Medical information is considered confidential and cannot be freely shared among agencies. It will, therefore, be wise for the camp intake worker to obtain written permission from the parent for a medical report from the doctor, hospital or clinic treating the child, if this has not already been received. This information should be in addition to the regular medical examination given by the camping agency's doctor, and not a substitute for it, since it will probably contain information about the child's handicapping condition rather than about the current state of his health.

Camp Records

There should be on file at camp, prior to the child's arrival, completely filled out application cards and an accompanying summary giving pertinent medical and social data that will enable the camp staff to understand the child. In every case, it is desirable that a camp report be sent to the sending agency when a child returns home, and the sending agency should request it. In making this report, the camp staff should keep in mind that the camping experience is an integral part of a youngster's year round program, and those responsible for his total program want and need all of the pertinent information they can get. The reports from camp should include such significant points as the camper's adjustment to the camp program; his ability to establish purposeful relationships with other campers and camp staff; what he was like as a person; what he was able to contribute to camp activities; and what he seemed to get out of his camp experience. It would also be helpful to know whether he used his disability as an excuse for not participating in activities and whether he persistently withdrew from the group. In addition, the sending agency would also be interested in learning about special abilities demonstrated while at camp.

The report should include comments by the nurse and physician relating to the child's health at camp, and whether any medical problems arose that could be directly attributed to his handicap.

Fees

In placing handicapped children in organizational, settlement or community center camps, payment of fee may prove to be an obstacle. The policy of most of these camps is to charge a person who comes as a referral, or from outside of the community, a standard fee despite the fact that a sliding scale is applied to applicants who come from the membership of the organization or from the neighborhood. Payment of this fee is not a problem when the referring agency has a fund for camp scholarships. Unfortunately, however, many hospitals and agencies do not have such funds. They therefore are unable to use camps which may be ideally suited for certain children.

If handicapped children are to be served in normal camps, both referring agencies and camps may have to re-evaluate their policies in this area. The hospitals and agencies would have to examine why they do not provide funds for camping referrals, and the camps would have to broaden their concept of the community to be served. This may not be a problem in all communities, but where it does exist, it is an obstacle to a child's attendance at camp which should be eliminated.

In setting fees with the parent, it will be well to remember that a family with a handicapped child often has greater medical expenses than the ordinary family.

GENERAL CONSIDERATIONS FOR THE REFERRING AGENCY

Description of Camp

Since many case workers, doctors, nurses and rehabilitation workers have never been to camp, we will attempt to give a picture of what camp is like. This is rather difficult to do because of the wide range of differences in philosophy, program and quality of service which exists in the field. However, if workers are to make good use of camps for their clients they must familiarize themselves with some of these differences. Of obvious importance are the location, fees and age limits of the camp. These facts, however, are just the beginning of the story of what camp is like. The philosophy, structure, pace and atmosphere of a camp are the central core with which a worker must be concerned.

Camp programs vary widely and will range from highly competitive and fast moving, to cooperative, leisurely and relaxed. Some camps have rigid schedules; others have no schedule at all. Camps are organized in a number of different ways, growing out of their philosophy. They may be activity centered, work centered, group centered, skill centered or treatment centered.

In the activity centered camp the child either chooses or is assigned to activities in which he wishes to participate for the day. Each counselor usually has some special program skill at which he works during the day. In addition, he may be in charge of one bunk which functions as a unit at mealtime, clean up, rest hour, bedtime and evening program.

In a group centered camp the children will be assigned to bunk groups mainly on the basis of age, interest and ability. They will participate in activities decided upon by this group as a whole. Group projects which may carry over for several days or for the whole trip are encouraged. Many group centered camps, however, provide for the child's individual interests through a scheduled hobby hour and free play periods. During these times the child can make new friends, work with other counselors and be away from his bunk mates.

The skill centered camp is one which stresses the learning of a special skill such as music, arts, dramatics, riding, pioneering. It also includes other activities, but the main emphasis is upon the development of the child's ability in the special skill.

The work camp, which is usually for adolescents, emphasizes participation in real work projects in the camp or neighboring community.

The treatment centered camp has certain therapeutic goals for the disturbed children it serves and may use many kinds of program organization to achieve these goals.

Any one of these types of camps may be located on any kind of terrain and housed in any kind of building. Terrain, for example, may be

very hilly, with rocky paths and great distances between areas, or it may be flat and compact. Buildings may be comfortable cottages with electricity and inside modern plumbing, or they may be tents or open-sided cabins, with toilets located at some distance.

No matter what kind of philosophy, program or facilities the camp has, one can expect that a child will be quite active during his entire stay at camp. A typical camp day may be as follows:

7:00 - 8:00	A.M.	Rising
8:00 - 8:30	"	Breakfast
8:30 - 9:30	"	Clean up of bunk and inspection, free play
9:30 - 11:30	"	Activity (this may include swimming or boating)
12:00 - 1:00	P.M.	Lunch Hour
1:00 - 2:00	"	Rest hour or quiet time
2:00 - 5:00	"	Activity (will include swimming)
6:00 - 7:00	"	Supper Hour
7:00 - 8:00	"	Evening program
8:30 -	"	Bedtime

This is a long active day which will include, as a minimum, swimming, sports, games, arts and crafts, and bunk clean-up. In addition to, or instead of these activities there may also be a cookout, a hike, a trip or a sleepout. There may also be a special all day program, such as a carnival, county-fair or a water show. The exact amount of activity will depend in part upon a child's sex and age group. For example, twelve year old boys will probably have a great deal of sports activity, while a younger group may be concentrating upon the collection of frogs, insects and the like.

In addition to participating in an active program, the child in camp usually does more walking and climbing to get from place to place than he would at home. Unless camp is quite small there will be considerable distance between the various living and activity areas. Most camps are either more hilly, rocky or rough than the terrain the child usually encounters in the city.

The physical activity of the child at camp is not the only new experience with which he may be faced. The fact that he will be living in a group may be difficult for an individual child. Group living requires cooperation, self control, discipline, as well as an ability to give and take and to enjoy being with people. The child has to be able to accept changes, new activities and ideas, as well as the rules and regulations of group living. Group living must be recognized as an integral part of camping. If the child is not ready for group living, he is certainly not ready for the camp which stresses this, no matter how much the worker feels he ought to be out of the city or away from his family.

Another crucial part of the camp program is the camp staff. The professional qualifications of the camp director, program director, supervisors and counselors establish the quality of the camp program. An immature, untrained staff cannot be expected to provide the quality of service many agencies are seeking for their clients. The higher the standards of the camp, the better the program will be and the more meaningful the child's experience will be.

A description of camp is incomplete without a mention of the pleasure which the child can have in camp. This is the reason why most children want to go to camp. However some children are initially very frightened by the country with its night noises, unknown insects and animals. Whether the child continues to be frightened or goes on to a pleasurable experience will depend upon the quality of the staff and of the service being offered by the camp.

Referrals

A referral of a handicapped child to a "normal" camp should be done as carefully as any referral is done. It should be remembered that it will often be necessary for a child with a disability to have his first camping experience in a more protected camp setting with the ultimate goal of his being able to move from his special setting to a normal camp situation.

For the child and his family such a referral can have a deep meaning of which the worker is well aware. However, the worker may not recognize when the family has an unrealistic picture of camping, since she may not be familiar herself with camp.

Often referrals are unsuccessful because the family may interpret camping as a threat to the wellbeing of the child. Sometimes the child may want to attend camp, but the overprotective parent may feel he should not be exposed to such an experience. There are, of course, innumerable ways in which a family may react and the referring worker has to be prepared to deal with these reactions, so that the child may go to camp.

Not only must the worker understand and work with the feelings involved in such a referral, but he must also have some knowledge of camping. Unfortunately, referrals are often made by workers who themselves have never attended, worked in or even visited a camp. They may not be familiar with the specifics of the camps in which they are interested. Lacking direct experience in camping and group work the worker may not be prepared to explore with the child what camping would be like. He may know that the child desperately needs an opportunity for socialization, but he may not know if the camp which he is selecting will provide this opportunity.

To make an adequate referral the worker should know the specific philosophy, program, structure, terrain, fees, qualifications of personnel and kinds of children served by the camp. Having ascertained these

facts he is then ready to make the next step in the referral.

In finding out about the camp and in describing the child to be referred, the worker will come in contact with the camp director, registrar or intake worker. These people will weigh the child's physical, emotional and social needs against what the camp can actually offer, in order to determine if he will fit into the camp program. They will make the final decision about accepting or rejecting the child.

Using the preceding discussions as a frame of reference, the following sections will outline some specific points to be considered in relation to the different diagnostic categories.

SPECIFIC DIAGNOSTIC CATEGORIES

ASTHMA

In general a camping experience will be helpful for a child with asthma providing that he is ready for a group experience away from home. Except for the severely involved youngster, children who have asthma should always be considered for a normal camp and not a specialized camp. He should be able to take part in the usual camp activities. There should be no need for restriction of physical activities except for a brief period of an hour after he has received an injection.

It is important that the sending agency take responsibility for careful medical and social screening of children with asthma before referring them for camp placement. The sending agencies have a responsibility to provide the camp with complete diagnostic information and an outline of any special treatment that a child might need if an attack of asthma occurred while he was in camp. The outline of medical treatment should include interpretation for camp personnel of the kinds of activities that a youngster can participate in as well as some of the limitations.

Description of categories within the diagnosis

Children who may be referred for camp placement fall into four main diagnostic groups:

1. Environmental Asthma

With this group of children their attacks are related to factors within their own immediate environment. They are particularly sensitive to dust or feathers and it is frequently necessary to modify the home situation to remove these irritating factors. Many of these children come from crowded living conditions and families in the lower economic status which make it difficult for the families to make such adjustments. Cultural factors also play a part in that the type and amount of furniture and the kind of bedding that the family use are in accordance with their own sub-culture patterns, hence it is difficult for them to accept the need for modification or change. In addition there may be tensions within the home due to crowded living conditions and low income which affect the inter-personal relationships and create an emotional climate which may prove to be the irritant to bring on an asthmatic attack. These children are usually under treatment all the year round.

Frequently with these children who have been under regular treatment throughout the year it may be possible to prolong the length of time between injections or to even give them a rest from this treatment during the period they are in camp, providing it does not go beyond a four-week period.

2. Pollen Asthma

It is in this group that the pollen from ragweed and grass are the irritant factors. The point to be kept in mind is that a child who is sensitive to grass pollen should be sent to camp in August since July 4 is the peak for pollen scatter from grasses. As far as ragweed is concerned the beginning of the ragweed season is August 15, hence a child sensitive to ragweed pollen should be sent to camp during the month of July. These children will need treatment while at camp and may have to be given injections once a week, once every two weeks or once every four weeks.

3. Food Asthma

Children who are allergic to specific foods such as egg, peanut butter or fish are likely to be the ones whose sensitivity problem might prevent them from attending camp. Of course, as with all types of asthma one finds the mild, acute or severe cases. With food allergies, however, these children do have to be on special diets, and in severe cases it is practically impossible to maintain rigid safeguards and be sure that a child's diet is free from those foods that bring on an acute asthmatic attack. For example, a child acutely allergic to peanut butter might have an attack brought on if he used a knife previously used to spread peanut butter. In such instances, these children should not even be considered for camp because of the problems presented by the need of rigid supervision not only of the foods included in his diet but also of utensils that had been used for some food capable of setting off an asthmatic episode.

4. Asthma with colds or infections

Usually these children do extremely well all summer long; their particular difficulty arises during the winter months when they are exposed to colds or acute infections. By means of injections they are well controlled and rarely have an acute episode during the summer.

Selection of Campers

Children who have an asthmatic problem which is mild should be accepted by camps for well children with the understanding that these camps have an adequate staff to provide good supervision for the individual child. Only those children who are well controlled and on adequate medication should be considered. The age for acceptance of children who have a problem of asthma should be determined in the same way as any child would be screened for admission. Due concern should be given to all phases of development (physical, emotional, social and intellectual), in order to determine whether he is ready for a residential camp experience.

Referral Statement

This should include a medical history as it relates to the child's

asthma, giving the specifics as to the agents that might cause an asthmatic attack. In addition, each child should go with a written notice that if he does have an asthmatic attack while at camp what medication is effective in controlling the attack. The referral statement should include the kind of medication being given the child, whether it is necessary for him to receive injections while at camp, and the amounts and frequency of injections. Also he should have with him, in addition to the statement about medication to be given for an asthmatic attack, sufficient medication while at camp. All medicicine should be turned over to the nurse.

Medical Supervision

A camp taking a child who has asthma should have a registered nurse as a full-time staff member and should either have a physician on the staff or one readily available. Children who need to be given injections while at camp should have these given by a physician who will remain to observe the child for at least twenty minutes after the medication is given. In addition to that the youngster should remain in an area where he can be observed during the next hour in case he might need help. During this period of time he should not participate in active games nor should he go swimming. It is important that the child who is susceptible to colds should be watched carefully. He should not be permitted to run around or sit around in a wet bathing suit and chilling is to be avoided. The physician should be easily accessible forcall if a child should get a sudden asthmatic attack.

Physical Set-up

The facilities and equipment of the camp should be comparable to the standards set up by the American Camping Association. Any factor which promotes the acquisition and spread of respiratory infections such as overcrowding, leaking cabins, inadequate protection against sudden weather changes is to be avoided. In general, the terrain of a camp accepting children with asthma does not need to be level nor do the buildings need to be close together.

Supervision of Camp Staff

The supervision of the child with asthma should be the same kind of supervision that would be given to any camper; encouraging some to be more active, restraining others who might have a tendency to participate to the point of exhaustion. The camp staff should be aware of the first signs of even a mild respiratory infection and be responsible for reporting this to the medical staff immediately. Some of these children may have been severely limited in their activities at home and may carry over this pattern into camp or may become extremely aggressive. It is necessary for counselors to have some understanding of the meaning of child behavior, as a help in knowing how best to handle such situations.

Program

The camping program should be similar to the type of flexible program advocated for any camp, having a balance between physically active games and a quiet activity with an opportunity given for group participation as well as for carrying out projects alone.

Children with asthma as part of their treatment are taught to stop physical activity at the point of fatigue, recognizing that when they begin to wheeze they have reached a point of exhaustion. They then sit and rest for fifteen minutes and are then able to return to their activity. It is desirable that these children continue to exercise this kind of control over their activities. Unless adequate protection can be provided that will eliminate the possibility of chilling or exposure to weather conditions that might bring on respiratory infection, overnight trips or camping out are to be eliminated from the child's activities.

In addition to the children described in this section there are those who have severe asthmatic attacks which negate their being sent to a regular camp. It is the sending agency's responsibility to plan the type of care needed for these children which usually would be in a convalescent unit rather than in a camp.

HEART DISEASE AND RHEUMATIC FEVER

A vacation in camp may be highly desirable for a child with heart disease or with a history of rheumatic fever. Because of previous illness or diagnosis of heart disease he may have been excluded from group activities or over-protected by his family. The socializing experience of camp may do much to encourage the development of a healthy personality.

Many so-called "cardiac" children can take part in all types of activities usual in camps for well children. Other children with heart disease can be handled successfully in camps having small living groups and a flexible program which allows a choice of activities so that more strenuous competitive sports can be avoided. There are some children with heart disease who should be accepted only by camps providing specialized programs and close medical supervision. As a correct cardiac diagnosis is essential it is recommended that camps accept those cardiac and rheumatic children for whom competent evaluation of their cardiac status can be arranged, either by the referring or by the camping agency.

Sending agencies have a responsibility to provide the camp with adequate diagnostic information and with an interpretation of the medical findings in terms of the child's ability to take part in camp activities, as well as an explanation of any special personality traits which might affect his adjustment. The camp in turn has a responsibility to send to the referring agency a report of the child's success in camp.

Description of Categories Within the Diagnosis

Children who may be referred to camping agencies fall into three main diagnostic groups:

1. History of Rheumatic Fever with or without resulting heart disease, includes history of acute polyarthritis and chorea(st. vitus dance). More than half of the children of camp age who have had rheumatic fever have little or no residual heart disease. They are, however, prone to recurrences of their rheumatic fever following infections (usually respiratory) caused by the hemolytic streptococcus. To prevent such "strep" infections children who have had rheumatic fever take sulfonamide or penicillin tablets daily or twice daily (prophylactic medication).

2. Congenital Heart Disease: the presence of an abnormality of the heart present from birth. Many of these abnormalities are so slight as to interfere in no way with a child's activities. Some may be completely or partially corrected by surgery.

3. In addition to the two groups above, children may be referred to camp as "cardiacs" with a diagnosis of Undiagnosed Manifestation (formerly called Possible Heart Disease). Such a diagnosis indicates the presence of some physical finding in the heart (usually a murmur) which

makes periodic medical observation desirable, but which is insufficient evidence for a diagnosis of heart disease.

To indicate the ability of a child to take part in physical activities a "FUNCTIONAL AND THERAPEUTIC CLASSIFICATION" is used. The functional classification indicates the capacity of the heart to perform as compared to a normal heart; the therapeutic classification the amount of limitation that is considered medically advisable. For example, a functional and therapeutic classification of IA indicates that the child's heart functions as a normal heart, and no limitation of his activities is necessary; a classification of IB indicates that although the heart functions normally, the added strain of severe competitive games is not considered medically advisable.

Selection of Campers

It is recommended that children diagnosed and classified as follows be accepted by the usual camps for well children, with the understanding that these camps have a staff adequate to provide reasonably close supervision of the individual child:

1. History of Rheumatic Fever, but with no attack within the year previous to camp.

   (a) History only, no heart disease(formerly called Potential Heart Disease)

   (b) History, plus Undiagnosed Manifestation(formerly called Possible and Potential Heart Disease)

   (c) Rheumatic Heart Disease, Functional and Therapeutic Classification IA.

2. Congenital Heart Disease, Functional and Therapeutic Class IA.

3. Undiagnosed Manifestation (Possible Heart Disease). These children, although they may be followed in a cardiac clinic, are not "cardiac" and should not be considered as such.

Camps having small living groups, close health supervision, and a program which permits choice of activity and so allows for the elimination of strenuous physically competitive games, may take, in addition to the groups described, children with rheumatic or congenital heart disease classified as IB.

Referral Statement

This should include history as it relates to rheumatic fever, time elapsed since last attack of rheumatic fever or chorea, diagnosis, func-

tional and therapeutic classification. It should also include an interpretation of the medical and social findings in terms of the child's physical ability and his readiness to take part in camp activities. A detailed statement as to any medicine he is to take at camp or other special needs should be made in writing. The referring agency has a responsibility to plan for adequate medication for the camping period.

Medical Supervision

A camp taking children with heart disease or a history of rheumatic fever should make provision for the prompt recognition, treatment and control of the spread of respiratory infections. Children on daily medication to prevent streptococcus infections should be supervised (usually by the nurse) to ensure that their daily pills are taken as directed. The camp medical staff should be alert and have the confidence of the children. While it is desirable to have a competent resident physician, a registered nurse with an experienced local physician, readily available to call, may provide equally good service. Camps should be aware of the hazards of streptococcal respiratory infections to children who have had rheumatic fever. They should provide sufficient health supervision to ensure the taking of any prophylactic medication prescribed, and the prompt detection and treatment of any respiratory infections which occur.

Physical Set-up

Camp site, facilities and equipment which equal the standards set by the American Camping Association are adequate for the type of child recommended. In general, camps accepting children with heart disease of Functional and Therapeutic Classification IB should be somewhat less "rugged" (as to terrain and distances) than those accepting Functional and Therapeutic Classification IA. Any factor which promotes the acquisition and spread of respiratory infections, as overcrowding, inadequate protection against sudden changes in weather, is to be decried.

Supervision by Camp Staff

The camp staff should give to the child with heart disease or a history of rheumatic fever the same objective supervision that would be given all children; encouraging some to take a more active part, restraining those who would compete to the point of exhaustion, and being ever alert for and reporting to the medical staff the first signs of even a minor respiratory infection. It should be borne in mind that some of these campers may have been overprotected and deprived of group activities, and are therefore fearful. Others, resentful of restrictions previously imposed, may be aggressive and inclined to do too much. Orientation of counselors and other camp staff should include emphasis on the hazards of respiratory infections to rheumatic children, as well as an explanation of other special needs; and it is important that these children use the rest hour for resting, and that they change promptly from wet to dry clothing to avoid chilling.

Program

A well-balanced flexible program will offer the choice of active and quiet activities desirable in any camp. Children with heart disease or a history of rheumatic fever should be encouraged to participate in a varied camp program including team sports, unless specifically advised against by the referring physician. It should be recognized that in any child excessive competitive drive may lead to an undesirable degree of fatigue.

In addition to the children described above who are recommended for inclusion in regular camps, there is a group of rheumatic and cardiac children who would greatly profit by a camping experience, but for whom a specialized program and close medical supervision is necessary. These are children with more recent attacks of rheumatic fever, and those with more severe rheumatic or congenital heart disease whose activities need to be markedly limited (Functional and Therapeutic classes IC - IIC).

DIABETES

A camp for non-handicapped children may reasonably be expected to take a child with diabetes if the child's own physician gives assurance that his diabetes is well controlled and that the child has sufficient self-discipline to resist the temptation to break his diet and training to recognize the symptoms of insulin reactions.

The older the child is, the more feasible it becomes to have him at a camp with non-diabetic children because he will have had time to have learned about himself in relation to his disease, and can be expected to cooperate without the strict control that is maintained at a camp operated exclusively for diabetic children.

Description of the Diagnosis

Diabetes is a disturbance of metabolism in which the body is not able to utilize carbohydrates properly, and sugar is often present in excessive quantities in the blood, and may or may not be present in the urine. The control of diabetes may be accomplished by dietary measures alone, or may require the periodic injection of insulin, daily or several times a day.

Some of the common signs of inadequate control of the diabetes are excessive thirst, excessive urination, and gradually increasing drowsiness and somnolence.

When the diabetic child is receiving insulin, over-dosage, though uncommon, may occur, sometimes shortly after the injection and at other times after intervals up to several hours. Over-dosage of insulin may produce a picture of shock, with sudden excessive sweating, tremor, anxiety, hunger, dizziness or double vision. This is an emergency condition and at the very earliest signs the reaction should be treated by administration to the child of sugar, usually given in the form of orange juice, sugar or candy. The diabetic child taking insulin should carry a lump of sugar or candy with him at all times so that insulin over-dosage may be treated without delay. In children these signs of inadequate control of the diabetes or over-dosage of insulin may be particularly rapid in onset and medical attention must be sought at once after the emergency measures have been taken.

Selection of Campers

The diabetic child is ready to go to camp when he has demonstrated some responsibility for taking care of his medical needs such as recognizing the symptoms of insulin reaction and taking sugar or candy to counteract this reaction if it occurs. The child also should be able to assume some responsibility for taking his injections and maintaining his diet. If he is socially and emotionally ready to do this in a group situation with non-diabetic children and understands and accepts himself in relation to his disease, he is ready for a regular camp.

Referral Statement

The referral statement to the camp should include information about the extent of the child's condition, whether it is controlled by diet or insulin, the dosage of insulin and the time of injection and whether the child should be encouraged to administer the insulin himself. The statement should also include a description of the signs of insulin reaction which the staff must watch for and the recommended treatment for such reaction. In addition, the sending agency has the responsibility of seeing that the child has sufficient medication to carry him through his camp trip. The referral statement should also include a copy of the child's diet.

Medical Supervision

In regular camps that accept diabetic children it is important that qualified medical or nursing personnel be available to supervise the diet and treatment of the diabetic camper. A nurse must be in camp and a physician readily available on call. A physical check-up a few days after arrival at camp is essential. Since camp life is more active than the life normally led by the child, adjustments in the amount of insulin and nourishment may need to be made. Part of the daily routine for a child is a simple urine test, hence facilities should be available so that it can be done.

The insulin, syringe and needles should be kept by the nurse who will be responsible for their proper care and use and will keep a daily record of the injections received. The nurse should be sure that there is plenty of insulin on hand and that the syringes and needles are sterile and in good condition.

Physical Set-up

Rugged type of camp facilities such as pioneering units are not practical for this group because of the need for adequate protection. Most terrains suitable for regular camps are all right for a child with diabetes.

Camp Staff Supervision

The counselors in charge of the diabetic child's activities should receive adequate briefing from the medical professional staff before the start of the camping season or in its very earliest days, to become aware of the signs of insulin reaction which the child's medical record describes. Since the child will be more active and may have such reactions, the counselor should be sure he has a quick supply of sugar always available. A couple of lumps of sugar should be carried by the child and the counselor at all times.

The staff should recognize that the child may not always like his

injections but that it is absolutely necessary that he have them and that he maintain his diet.

Program

The child with diabetes may participate in all games but strenuous and quiet activities should be alternated. Overnight hikes are not practical because of meals, possible night reactions and inadequate protection from the weather. However, outdoor cooking is permitted with dietary consideration.

Because many children have been overprotected at home, they may not respond to group play as readily as normal children. They may be used to doing things on an individual basis, and quiet activities, such as arts and crafts, are popular. With proper handling, however, such children adjust to group play and should be encouraged to do so.

A child with diabetes has to learn about himself in relation to his disease and how to cooperate without the strict control that is maintained at a camp operated exclusively for children with diabetes. One of the main objectives for the operation of NYDA, the New York Diabetes Association Camp, is the education of the juvenile diabetic under favorable conditions. This training will be of value to him for the rest of his life, as the more the diabetic knows about his condition, the more intelligently he can cooperate with his physician. This results in a more normal life with fewer medical complications due to his diabetes.

EPILEPSY

A child with epilepsy whose seizures are well controlled by medication and if he is ready for a camping experience, should have the opportunity to go to a regular camp. The majority of these children attend school and participate in the usual children's activities.

The child who has frequent seizures (one or more a week) or other physical difficulties and the seizures are a part of his disability, may require special placement. The sending agency has the responsibility of referring a child to the camp best suited to meet his needs and the severely involved youngster should be referred to a special camp.

Because of the stigma attached to the term epilepsy, the child with this diagnosis may have had limited opportunities for active participation in social groups of his own age. A positive camp experience will help him feel accepted by his peer group and adults, and encourage him to move into a group situation.

Description of Categories within the Diagnosis

Seizures are infinitely varied in form but there are two main types to be considered here.

1. Grand Mal

This type of epilepsy is most frequent. During an attack the child loses consciousness, his muscles tighten and he twitches for a minute or so. Usually he will lie relaxed within a few minutes, and may sleep heavily for a short or long period of time. The child may get up soon after the seizure, but feel dull or seem confused for an hour or so.

2. Petit Mal

In this type of epilepsy the seizures are often overlooked since they last only a few seconds. There may be a brief twitching of eyelids or eyebrows, or a momentary vacant stare. The child does not lose consciousness and within a few seconds will continue his interrupted activity.

Many of these children, when they have reached the age to be considered for camp, can give an account of the sort of seizure to be expected. They have learned to recognize some kind of warning before a seizure starts and will often assume responsibility for whatever subsequent treatment, such as sleeping or resting, they require.

The warning will vary with the individual child. It may be a "queer feeling" in the stomach or a feeling of dizziness. The counselor or some of the children who are with a child who has epilepsy may recognize the onset of an attack because of his unusual irritability, pallor or enlarged pupils.

There is no treatment to be given during an attack. An effort should be made to protect the child from injury and place him in a lying down position where he can remain until the attack is over. Occasionally it is helpful to place a handkerchief in one side of his mouth between the back teeth.

Selection of Campers

Children who have epilepsy that is controlled by medication, and whose seizures are infrequent should be considered by regular camps if there is an adequate staff to provide good supervision for the individual child. The criteria for the age level of acceptance of a child with epilepsy should be the same as that for any child being screened for admission. The main consideration should be whether he is ready for a camp experience away from home.

Referral Statement

An adequate social and medical statement is necessary in order for the camping agency to determine if the child will be suitable for their camp. The statement should include the kind of medication being given the child, the dosage and when taken, as well as a description of any special treatment a child might need if a seizure occurred while he was at camp. It will be important for the camp staff to know whether he has assumed some responsibility in taking his medication regularly. In addition, there should be a description of the seizure, its beginning manifestations and whether the child usually sleeps, and if so, how long after an attack. The information should include the kinds of activities he can or cannot participate in while at camp. It is the sending agency's responsibility to be certain that a child goes to camp with sufficient medication to last during the camp stay.

Medical Supervision

A camp taking a child who has epilepsy should have a registered nurse as a staff member and a physician readily available. The responsibility for supervising the medication may be a shared one between the nurse and counsellor, depending on the child's age and his readiness to assume some of this responsibility himself. There should be adequate provision made for a child to sleep or rest after an attack. He should be encouraged to relax if he seems confused after recovering consciousness.

Physical Set-up

The physical set-up of the camp and the facilities should meet the standards outlined by the American Camping Association. The terrain does not need to be level. If a child goes hiking in a mountainous or precipitous terrain he should not go alone, but be with a group.

Supervision of Camp Staff

The supervision of the child with epilepsy will be the same as that given any camper. Some of these children need to be encouraged to be active and participate with the group. Sometimes a child may have been isolated from his peers because of the limitations parents may have put on the child's social opportunities. The counselors should have some understanding and acceptance of the child's medical problem, should know how to act and not be upset if a seizure occurs, and be able to encourage him to participate in the camp activities.

Program

As long as seizures are infrequent, the incidence of accidents is no greater than would occur in any group of children engaged in an active camp program. The program should be a flexible one and provide a balance between active and quiet games, and have both group and individual projects. Moderate precautions are necessary for a child whose seizures occur more often than once a month and closer supervision may need to be arranged during swimming, boating, ladder climbing or out-door cooking. There are no other limitations necessary.

HARD OF HEARING AND DEAF

It was once the philosophy of educators that children who were hard of hearing should be segregated in all educational and recreational situations. Modern thinking on the subject favors integration of these children within the normal group where this is possible. Extensive experimentation has shown that hard of hearing children who have been "well rehabilitated" can successfully participate in activities with normal children. It is necessary however, for those responsible for the group to be aware of any special problems these children may have.

Description of Categories within the Diagnosis

Hearing loss in children may be due to any one of several causes: the result of an acute disease or a chronic disease process, a concomittant of another disease entity (such as cerebral palsy), or the result of trauma. Hearing loss may be either acquired during the life time of the child or it may be congenital. Hearing losses can be classified into two main types:

1. Conductive

A conductive type loss is generally a result of chronic ear infections or some traumatic injury to the ear mechanism. When a child with this type of hearing loss is fitted with a hearing aid he generally has little difficulty in adjusting to the wearing of it.

2. Perceptive

A perceptive type hearing loss is more often the result of a specific disease (mumps, measles, encephalitis), a part of another disease (cerebral palsy), or a result of a familial or hereditary condition. Because of the nature of the pathology this child may have difficulty in discriminating between sounds. Since his loss is mainly in the high frequencies he may have trouble in understanding the differences between certain words, such as pin, thin, fin, tin. He may not hear at all certain high frequency words or sounds such as bells and high pitched whistles. He may jump or show a startled reaction to certain very loud noises. A child with this type of hearing loss may have some trouble in adjusting to the wearing of a hearing aid if his difficulty is severe enough to warrant one.

Some children with severe hearing defects who have not received early treatment or have had difficulty in accepting and learning to use a hearing aid may have imperfect speech patterns.

Selection of Campers

Children who are hard of hearing and those with severe hearing defects should be placed in a camp with children of normal hearing and should not be segregated within the camp setting.

It is assumed that no child who is hard of hearing will be accepted

at a camp for normal children unless he has been seen at a hearing rehabilitation center and has been fitted with a hearing aid if this is possible.

The age level for selection of children with hearing defects does not differ from the age level for children without a hearing disability. Selection of the child should be determined by his developmental levels and his readiness to go to camp.

Referral Statement

This statement should include sufficient medical information in order for the camp staff to understand the child's particular disability and the limitations it places upon him, and such treatment procedures that should be continued while he is at camp. The physician's orders regarding ear plugs and other preventative measures should be clearly stated and should indicate whether the child is permitted to go swimming (especially diving).

It is important that the type of appliance worn by the child be indicated as well as the number of hours and when the hearing aid is to be worn. The volume and tone control setting for the child's hearing aid should be indicated and also specific information about the workings and care of it. Most hearing aid companies supply an instruction booklet with the aid and a copy should be sent for use by the camp staff. The hearing aid has batteries and cords that do wear out. The child should have a sufficient supply of batteries and cords with him to last his camp stay.

The social history should include information about the child's adjustment to his hearing defect and his feelings about wearing the hearing aid (if he has one). If he has a speech defect it should be noted with any pertinent data that will help the counselor understand the problem and how she can maintain continuity in the specific parts of his program that should be continued while he is at camp.

Medical Supervision

It is desirable that a camp taking a child who is hard of hearing or deaf have a registered nurse as a full-time staff member and a physician readily available. It is important for those persons in charge of such a child to be familiar with the workings and the care of his hearing aid. The great majority of children wearing hearing aids are using what is called a transistor type instrument. In practically every instance such an aid consists of the main case, wherein is housed the battery and which contains also the volume and tone control, a cord leading to the receiver button, and an ear mold which is fitted directly into the child's ear.

Most batteries have a life of from two to four days. In order to tell whether a battery is working, place it in the aid, turn the aid on, and hold the receiver button close to the microphone. If there is a whistling sound the battery is good for some degree of use. Each night the battery should be removed from the case and the hearing aid should be

turned off in order to increase the life of both aid and battery. Extra batteries should be given to the nurse for safe keeping and should be kept in a cool, dry place.

A hearing aid cord is usually good for about two months. However, active children often use more frequent replacement. The camp should have two extra cords on hand. One way to test the cord it to put a new battery in the hearing aid, place the receiver button near the microphone, and turn the hearing aid on. If there is no whistle, or if manipulation of the cord causes interruption of the whistle, chances are that the cord is defective.

The ear mold is made of either lucite plastic or rubber plastic material. Each night the ear mold should be detached from the receiver button and cleaned with soap and water to remove wax. The passage way of the ear mold should be cleaned out with either a pipe cleaner or some cotton wrapped around a tooth pick.

It is important for the hearing aid to be anchored securely during the child's activities; either a homemade or a company provided harness is effective. Hearing aids must be kept dry at all times, therefore the child must not wear his instrument while bathing or swimming.

Physical Set-up

The facilities and equipment of the camp should be comparable to the standards set up by the American Camping Association. There are no limitations as far as terrain is concerned unless the child has an additional handicap that would contra-indicate an excessively rough terrain. Children who are hard of hearing or deaf need to be placed with children with good hearing so that they can be informed of any emergency which arises, especially at night. A buddy system set up in the group would be helpful.

Supervision of Camp Staff

Staff member, especially those counselors who are going to be directly responsible for the child with a hearing defect, should understand the medical recommendations, the type of disability, the kind of appliance (if the child is wearing one) and its care and adjustments. The child's problems should be understood and taken into consideration when carrying out activities.

There are several general considerations that must be observed in dealing with a child who is hard of hearing. These are: (1) in speaking to the child, call his name first in order to get his attention (2) if possible do not call the child from a great distance (3) in an activity where the children are seated, have the hardof hearing child sit in the best position for him to hear what is being said. The speaker should try to keep his own face well lighted so the child can utilize his lip reading ability.

If the child wears a hearing aid the counselor should have a copy of

the brochure that goes with it and be prepared to help the child with proper insertion of batteries and their testing to determine if they need to be changed. The volume and tone control should be set each morning and a piece of scotch tape placed over the controls to prevent their being moved by the child when in strenuous activity. Encouragement but not force should be used to help the child wear the aid as recommended. Whenever possible, the child should be given an opportunity to improve his speech and lip reading.

Program

The child with a hearing defect can actively participate in an overall camp program where there is a balance between active and quiet activities and with an opportunity for group participation as well as working on individual projects.

Since this section of the Guide is concerned with children with hearing defects from a slight impairment to complete deafness, some parts of a camp program need to be discussed from the standpoint of (1) children with hearing defects including the deaf, and (2) children who are deaf.

1. For all children with hearing defects, including the child who is deaf, the following points should be remembered. In all group activities, such as athletics, dramatics, dancing and singing, the child should be allowed to place himself for best use of his hearing and for lip reading. Counselors need to be aware of the fact that the greater distance from the source of sound, the greater difficulty the child has in hearing. For swimming a buddy system will help the child to understand directions given by the counselor. Swimming (especially diving) should not be allowed unless the physician has given approval. The physician's orders regarding ear plugs and other preventitive measures should be meticulously carried out. Certain activities like boating, pioneering and hiking should be with others of normal hearing so that the child can be alerted to danger and hazards.

2. For those children who are deaf dramatics may be presented in pantomime. Dancing may be accomplished by placing musical instruments on the dance floor so that the child feels the vibrations.

ORTHOPEDIC DISABILITIES

A child with a physical limitation is ready to go to camp with physically normal children when he is able to care for his daily needs, has learned to function within his physical limitations, can dress and toilet himself, and if he wears an appliance, has learned to apply it and take care of it.

Regardless of diagnostic category, there are two points which must be given special attention in selecting a particular camp for the individual child: first, his physical limitations with regard to physical set-up including terrain and second, his adjustment and his ability to function within these limitations.

The extent to which the child can function successfully depends not only upon the degree of physical involvement but upon his adjustment to his limitations, his ability to relate to other people, to move into situations and participate in the various camp activities. The child's own motivation plays a very important role in his ability to achieve satisfaction within his physical limitations.

Description of Categories within the Diagnosis

Some of the conditions which result in physical limitations are:

1. Post Polio

The fact that a child once had polio tells nothing about his ability to function. The residual muscle weakness may be mild, moderate or severe and it may involve a hand, an arm, shoulder, one or both legs. Depending on the degree of muscle weakness a child may wear a supportive appliance like a hand splint, a shoulder splint or a leg brace. There are two important factors to be considered by the referring agency and also by the camp accepting such a child. First, how well does he function with his appliances, and second, can he function at all without them?

If a camp accepts a child who cannot function without his appliances, they should plan ahead to meet an emergency if it arises. The camp should know in advance those children who may need some help with things like cutting meat and tying shoelaces.

In considering camp placement for a child who had polio during the past twelve months, the child's physician should determine whether a camping experience is indicated for the child and if so, whether this should be a regular camp or a specialized one.

2. Cerebral Palsy

In this diagnostic category as in all others, major consideration must be given to the ability of the child to function within his limitations. There is a tendency to accept or reject these children on the

basis of physical appearance. The physical appearance of the child is, however, no indication either of his intelligence or his ability to function successfully within a group. There is no "right" or "wrong" way of performing a particular activity and the child's walking, dressing and eating patterns represent the best way for him with his particular limitation.

In cerebral palsy it is not only the diagnosis but the classification which must be considered when selecting camp, because the classifications carry with them special kinds of problems which must be taken into account by the referring agency and the camp accepting the child. Generally speaking only the children who are mildly involved are feasible for camp placement with physically normal children. If moderately involved, the child should have at least one good arm and one good leg; or two good arms. The child who has an involvement of all four extremities would probably do better in a specialized camp.

In no other condition is there greater need to make allowances for individual differences and deviation in speed, motor coordination, character or speech, special abilities and interests than in cerebral palsy. The physical limitation may be mild, moderate or severe; the child may wear one or more appliances. These appliances serve two main purposes: first, they help the child to function better and second, they prevent contractures from occurring. It is imperative, therefore, that the child wear his braces even though he may be able to get about without them. It is important that the camp accepting this child plan ahead to meet the possible emergency of a broken brace.

The two most common types of cerebral palsy are:

(1) Spastic: Presents a picture of jerky movements which are exaggerated when the child is faced with a new or a too difficult task. Because of his inability to perform certain tasks the child may "stop trying". This may be an indication that he is being asked to perform above his ability or is feeling too much pressure upon him to compete with other children. In considering children diagnosed as spastic, only those who have adequate use of one arm and one leg or two arms should be considered for regular camp.

(2) Athetoid: Presents a picture of purposeless movements, a constant twitching of facial grimaces which are involuntary. These movements may be exaggerated when the child is trying something new or when he is tense. Like the child with spastic cerebral palsy he may react to repeated attempts which end in failure by not "trying". In considering those diagnosed as athetoid,

placement in a regular camp should be limited to those who can get around by themselves, either with or without bracing.

There is a tendency to regard all children with cerebral palsy as being mentally retarded. This is not true. Many children in this classification function at a lower level than their chronological age partly from lack of socialization with their peers, lack of the normal experiences which the unhandicapped child has, lack of opportunity to explore the physical environment (this being particularly true of the congenitally involved child). These things make the child function best at an age level younger than his chronological age, but this does not necessarily mean that the child is mentally retarded. For example, one expects a child of 7 or 8 years, functioning at his age level, to be able to share his toys and playthings with other children, but a 7 or 8 year old child with cerebral palsy may be functioning on a 5 - 6 year social level and cannot be expected to produce this behavior. In the best interests of an effective experience for this child no pressure should be placed upon him to function at a higher social level.

A rather large number of children with cerebral palsy may have difficulties with speech or hearing. The speech problem may be because of involvement of the tongue or throat muscles in which instance the child has difficulty in forming words. This results in a slow, jerky or explosive speech pattern which is sometimes almost unintelligible. However, generally speaking, if the child is given sufficient time and does not feel pressure, he can be understood. Sometimes the speech difficulty arises from lack of stimulation to talk; the family may have formed the pattern of anticipating all of the child's wants and therefore, there is no need for him to develop a speech pattern. There should be awareness of needs for which the child may have no words, but he should be encouraged to use all the language he has.

There may be problems with regard to hearing losses, but since these are not unique to the child with cerebral palsy they will be discussed under the section related to Hearing Disabilities. Some children with cerebral palsy may have the additional problem of being subject to seizures usually controlled by medication. More information will be found in the section related to Epilepsy.

To many people the facial grimaces, the twitching and the extraneous involuntary movements of the child with cerebral palsy are very disturbing and they tend to avoid all contact with them because they are seeing the disability and not the child. This rejection creates an atmosphere which is most detrimental to the child. Therefore, unless the staff members are consciously aware of the impact of their attitude upon the child, the acceptance of such children is contra-indicated.

3. Muscular Dystrophy

The selection of camp placement for a child with muscular dystrophy is largely dependent upon his stage of physical functioning. In the early stages, when the child is still ambulatory and can climb steps, he will in general fit into a camp with the physically normal child. However, in attempting to match the pace of other children he may fall or suffer from muscle fatigue which tends to increase his physical disability. In this particular diagnostic category, fatigue tolerance is one of the individual difficulties to be considered in planning camp placement.

Another facet of this medical problem is the attitude of parents toward the progressive nature of the disease. If the family has adopted a fatalistic attitude about the child's condition he himself will reflect it and tend to do less than that of which he is physically capable. This is the child who needs encouragement, but not pressure, to use his physical potential.

In muscular dystrophy the hands are usually the last to become weak and therefore, major satisfactions for this child will tend to be in hand activities rather than in active games, which require walking and running.

4. Amputees

Amputation may be congenital or acquired, and may involve a hand, arm, both arms, one leg or both legs.

Since the trend at the present time is to train children at a very young age in the use of the appropriate prosthesis, by the time a child has reached camping age he is usually quite proficient in its use and generally speaking can take part in most of the activities appropriate to his age group.

In the case of unilateral amputations, either one arm or one leg, or one arm and one leg, a child who has been trained in the use of his prostheses can function quite well in a camp with physically normal children.

In the case of double amputations, such as both arms or both legs, the child should be placed in a specialized camp.

This is another situation in which the staff members' attitude toward the child with this body disfigurement is especially important. The attitude of the child toward his prosthesis may be quite different from an adult's attitude. In fact, he may regard it as something to show to other children with pride. This should not be frowned upon by staff members.

The referring agency should make sure that the prosthesis is in good working order when the child goes to camp, and the agency accepting such a

child should be prepared to meet emergencies. It is important that these children be encouraged to wear their prostheses in accordance with medical recommendations.

Selection of Campers

The age level for children with physical limitations does not differ from the age level for children without physical limitations, but is based upon the child's growth and development, his readiness for the experience and the degree to which he can achieve satisfaction from camping. Children who are recovering from acute illness or operative procedure should be considered for camp only on medical recommendation.

Referral Statement

This statement should include sufficient medical information in order for the camp staff to understand the particular disabilities and the limitations these place upon the child and should also include orders for medications or treatments which are necessary while the child is in camp. It is important that the type of appliance worn by the child be indicated, the number of hours per day the appliance is to be worn and specific information about whether knee or hip locks are to be open or closed when walking and if open, how long in any twenty-four hour period they should be locked to prevent contractures.

The social history should include information about the child's adjustment to his disability, his feelings about wearing the appliance as well as his ability to actively participate in group situations, his usual peer group and his particular interests. In selecting a camp for a child with physical limitations the referring agency must be thoroughly familiar with the total camp program, including the physical set-up.

Medical Supervision

A camp accepting children with physical limitations should have a competent registered nurse on the staff and should have available on call the services of an experienced local physician. These children are subject to the same hazards of upper respiratory infections, minor scrapes and bruises as other children. The nurse should have the responsibility for the daily administration of medication, inspection of skin of the children who wear appliances and braces for reddened areas or pressure sores. If a child is to have a period during the day when his braces are locked at hips and knees, the nurse should supervise this.

Physical Set-up

Children selected for camp will be able to get about on fairly rough ground, climb steps and in general manage very well. However, excessively rough terrain, rocks, narrow paths through wooded areas might be reason for not accepting children with physical limitations. The distance the child needs to walk from one activity to another, or the length of time he

must remain in a wet bathing suit are also factors to be considered.

Camp Staff Supervision

Camp counselors and other staff members during their orientation period should be helped to acquire an awareness and understanding of the problems that children with various physical disabilities may bring with them to camp. In addition, those counselors who are going to be directly responsible for children in this category should be given an interpretation of the medical recommendations, the type of disability and appliance, if the child is wearing one. The camp staff should provide the same objective supervision that would be given all children, encouraging some to be more active and helping others to reduce their activity so that they will not become exhausted. Counselors should be alerted to be observant of children using appliances for redness of skin indicating brace pressure which could cause sore areas. They should also watch for any signs of upper respiratory infections or other acute conditions to which children are susceptible. All children need understanding and acceptance by camp personnel.

Counselors should encourage the child in taking care of braces and crutches and keeping them out of the way of others when not in use.

Program

The camp which focuses upon small groups in most instances would provide the best kind of camp setting for these children. Such a flexible program, makes it possible for a child to have some choice of activity and lessens the chance of his being involved in highly competitive games. These youngsters can compete in sports and games and the counselor needs to be resourceful in modifying some of the rules to meet the physical limitations of these youngster, so that they can actively participate in their group. However, if the child does not want to participate in the very active sports, he should not be pushed into doing so.

As far as selection of different activities in accordance with age levels, the same criteria should be used for these children as for any other child. It is important for these children, as for all others, that they have adequate rest periods, that they change promptly from wet to dry clothing and that physical activity to the point of an undesirable fatigue be avoided.

VISUAL (including the Blind)

This section is concerned with the child who has a severe visual handicap. Some of these children can be accepted in a regular camp and will prove to be good campers. Such a group experience will not only be valuable for the child with a severe visual handicap or the totally blind, but is considered a necessity when the child is ready for a group experience. It will provide the opportunity for him to reach out and control his environment and to purposefully use his free time. He lives in a sighted world and needs to be helped to learn as early in his childhood as possible how to live in his environment and derive satisfactions from it. There is an educational value in having these children with sighted children. These experiences can be enriched because of their using other senses than sight, such as hearing and touch to see and appreciate things.

Attention needs to be given by the camp staff to forseeable hazards, grounds, protruding objects. These need to be related to the child and the program. Good safety practices for all children are generally sufficient.

Description of Categories Within the Diagnosis

The degree of visual disability ranges from the very mild involvement to severe disability, including total blindness. There are many children who are mildly and moderately visually disabled who can capably cope with nearly all of the situations encountered in camp.

Visual disabilities may be congenital in origin or acquired. There are certain eye conditions that might indicate some limitation of strenuous physical activity.

Legal blindness, according to the New York State Commission for the Blind is 1/5 or less of normal vision. Because of this definition there are wide differences in the abilities of the child with a severe visual handicap. These abilities are closely related to the psychomotor functioning of the child and whether he is motivated to use them.

The child with a visual acuity of 5/200 or less operates on a tactual level although they have light and motion perception. The child with a visual acuity from 5/200 to 20/200 is partially blind, but will operate primarily on a visual level and has some object perception.

A child with any degree of vision may safely use that vision in a normal camp experience even though at times, he uses it in a distorted fashion by bringing things close to his eyes. Use of the eye for perception of objects is not damaging but the focus at which a child can see an object may seem unnatural.

With the sensory handicapped, rearrangement of activity is by substitution rather than compensation.

Selection of Campers

A child who demonstrates that he can understand his environment and handle the frustrations that arise when he is orienting to a new environment without too distressing reactions is ready for a camp experience. He may not be ready for this experience at the usual age children have their first camping experience. The limitations of their environment have radically curtailed opportunities for group experiences. At age eight or nine he may be ready to derive satisfaction from a camping experience.

Referral Statement

This statement should include complete medical information about his general health as well as a report of the ophthalmologist's examination which should have taken place within the past six months to a year. Interpretation should be given regarding the child's visual acuity, visual efficiency and activity limitations.

Specific recommendations should be given regarding medications, prosthesis and wearing of glasses. A prescription for glasses or an extra pair of eyeglasses should be sent with the child and given to the nurse.

The social information should include a statement about the child's adjustment to his disability and his ability to actively participate in group situations.

Medical Supervision

There should be a competent registered nurse on the staff who will assume responsibility for carrying out medical orders sent for the child. A physician should be readily available in case of an emergency.

Physical Set-up

The terrain is not important. If the child is taken by the counselor around the camp and shown where there are rocks, steps, buildings and trees as well as the pathways he will soon be oriented to the physical arrangements. He needs to have an opportunity to explore the camp ground set-up and his bunk in his own individual way with the help of the counselor or a "buddy". In strange or new or rugged situations while at camp the counselor or a "buddy" should hold the child's arm or walk just ahead so the youngster can touch his leader's shoulder.

Camp Staff Supervision

Camp counselors and other staff members should be helped to acquire an awareness and understanding of the problems that children with visual handicaps bring with them to camp. The counselor should

keep the following points in mind. The child's adjustment to camp is an educational one not an emotional one. His chief substitutes for his visual limitations are sound and touch. Physical contact with the child is important (putting hand on shoulder) when telling him to do or get something or when giving other kinds of directions. When teaching a song with gestures the youngsters' hands should be put through the motions. If the child's mail needs to be read to him, it should be read as written and without ommissions or interpretations. The counselors need to keep in mind that the giving of directions must be specific; for example, the steps to the swimming pool are on the right side of the path.

There are some mannerisms exhibited by the child with a severe visual handicap that are called "blindisms". These usually occur when he is bored or depressed or feels left out of the group. A counselor who observes the child hanging his head, pulling his ears or poking at his eyes should be aware of the possible reasons for this behavior and help the youngster to involve himself in the group's activity.

Program

The child should be the one to decide whether he can or cannot take part in an activity. The counselor should encourage the youngster to tell what he can do because he has developed his own way of doing things that are satisfying to him. He can be very creative in discovering ways of doing things.

In nature study, his seeing of a flower, leaf or moss is by his feeling of the objects as they are described. He can learn to identify trees in the same way. His tactual exploration will encourage the child with sight to do the same, thus deepening appreciation of the things they formerly saw with vision alone.

The chief difficulty tne child with severe visual limitations will have in program activities is in competitive games. He can participate in many active games, but not when acute vision is needed (such as, base ball or volley ball). He can be taught to swim in the same way other children are taught - by being held and his arms and legs put through the motions.

These children can play shuffle board well, can pass balls, play tag games and other group games. They can participate in hiking, cookouts, music, drama, dancing and crafts. They have to learn that they can not do everything.

Acceptance of a child who is blind is apt to create alarm in the minds of the camp staff. Referring agencies can provide some simple guides for the camp staff and should be willing to give consultation services. The camping agency should feel free to request such consultation services.

OTHER LIMITING CONDITIONS

In addition to the physical disabilities described, there are two other conditions which often keep children from attending camp. We will make only brief mention of them in this Guide. Detailed information can be obtained from the agencies specifically serving these children.

Mentally Retarded

Camps also should consider accepting children who are slow mentally, but not grossly retarded. Many of these children do make a good social adjustment in school, in church life, in their neighborhoods and homes with groups of children. They need and benefit by wholesome group living. The fact that the child is in a class for mentally retarded children does not preclude his acceptance at camp. If the report from the referring agency indicates that the child is attending school and has made a good social adjustment, and has not exhibited any severe behavior difficulties, there is every reason to believe that he should be accepted in camp. With this group of children it is important that they should not be automatically grouped with children of their mental age, but should take their place with children of their own chronological age. However, this policy should be flexible, and where it is known from parents and sending agencies that the child consistently selects playmates younger than himself this fact should be considered in placing him in camp activities. Social maturity, rather than mental or chronological age, should be one of the criteria for group placement.

Emotionally Disturbed

Camps have an important contribution to make toward the readjustment of emotionally upset children. To many such children, the camp experience provides the first opportunity to form real friendships, to take part in social group activities, to learn to do new things and help the reestablishment of self-confidence and self-regard. To the child who has been rejected it may mean the first opportunity for acceptance by understanding adults; to the child who has been overprotected at home this may be his first opportunity to learn he can get along without the presence and help of his parents. For the shy child, this may be the first opportunity to be a member of a group.

All persons familiar with camping are aware that any child may present a problem of adjustment to a new situation. They may manifest this by becoming homesick, fearful of participating, aggressive, enuretic, overdependent or by displaying a number of other relatively temporary symptoms. Most camps expect these symptoms from their campers. The children about whom there is question are those who are known to have definite emotional problems at the time of referral to camp. However, barring behavior on the part of a child that is either hazardous to the safety of himself or the group, or behavior that definitely limits to too great an extent the program and purpose of group activity (in which case the interests of the group must be considered first), many emotional difficulties, after careful

screening by the sending agency, can be dealt with in the group.

Experience has proved that the average camp can absorb, without too much difficulty, some children with "behavior problems" and provide an important contribution to their growth and development.

CONCLUSION

It is clear that there are many physically limited children within these disability groups who can fit into regular camp life. At the same time there are also many who require care which can only be given in the specialized camp.

The successful placement of the child in the camp which will fit his needs best will largely depend upon the degree of cooperation and sharing of knowledge between the referring agency and the camp. Without full information about the child's and the camp's limitations there can be no certainty that the correct placement will be made.

As has been indicated certain adaptations of program may be necessary to make possible the child's participation. It should be remembered that if the rest of the group is constantly limited because of the handicapped child, his presence may be so resented that he will never be accepted by the others. For example, having able-bodied boys always hop when playing baseball or keeping them from an overnight trip because of the handicapped child, will be a frustrating experience. This frustration may easily turn into anger or hostility against the child and even the counselor. A realistic balance of adjustment by both sides must be maintained. It would be a serious error if the groups's program was based largely upon the special needs of one or two youngsters.

Experience has shown that carefully selected handicapped children can do well in regular camps. Not only do they derive immeasurable benefits from a good camping experience, but they make their contribution to the pleasure of their fellow-campers.

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